



## Authorization for Dispensing Medications to Children or Youth Short-Term Medications (Prescription and Non-Prescription)

**Prescription medications** must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. **Non-prescription medications** can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label.

### Medication #1

First and Last Name of Child or Youth

Name of Medication

Reason for Medication

Dose                      Time to be Given                      Stop Date

Name of Licensed Physician/Nurse Practitioner  
prescribing the medication

( )  
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature    Date

### Medication #2

First and Last Name of Child or Youth

Name of Medication

Reason for Medication

Dose                      Time to be Given                      Stop Date

Name of Licensed Physician/Nurse Practitioner  
prescribing the medication

( )  
Phone number of Health Care Provider

I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.

Parent's Signature    Date

**THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.**

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

\*Signature of Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

\*Signature of Person Administering Medication \_\_\_\_\_ Initialing as \_\_\_\_\_

## Note Form

[illegible]



## HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

### Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
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First and Last Name of the Child's or Youth's Mother or Guardian
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Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )
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Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )
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First and Last Name of the Child's or Youth's Father or Guardian
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Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )
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Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )
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Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)
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Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )
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Name of Hospital Preference in case of emergency.
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Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.

Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior

Other: Please describe.

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed
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If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?
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I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed
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